

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
<http://www.dlp.vermont.gov>
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 4, 2016

Ms. Wanda Waugh, Manager
Canterbury Inn
46 Cherry Street
Saint Johnsbury, VT 05819-2290

Dear Ms. Waugh:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 11, 2016**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

MAR 03 2016

PRINTED: 02/22/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0119	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER CANTERBURY INN			STREET ADDRESS, CITY, STATE, ZIP CODE 46 CHERRY STREET SAINT JOHNSBURY, VT 05819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite investigation of an entity reported resident to resident incident was completed on 2/11/16. The following regulatory violation was identified.	R100			
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report, as required by 33 V. S. A. 6903, within 48 hours of awareness, a suspected incident of physical abuse between two residents (Residents #1 and #2). Findings include: Medical record review on 2/11/16 revealed that Resident #1 and Resident #2 had engaged in an argument which escalated to a physical altercation at 12:30 PM on 7/31/15. Written staff notes and Registered Nurse (RN) documentation indicated that the RN was aware of the altercation that same day. The resident to resident physical altercation was reported to Adult Protective Services (APS) on 8/4/16 at 2:11 PM, which is outside the required 48 hour reporting timeline. At 11:23 AM on 2/11/16, the RN confirmed that the report to APS was not within 48 hours.	R206	AS OF FEBRUARY 11, 2016 THIS FACILITY WILL REPORT ANY AND ALL ALTERCATIONS BETWEEN RESIDENTS, OR ANY AND ALL INCIDENTS OF ABUSE, NEGLECT OR EXPLOITATION OF A RESIDENT TO THE STATE OF VERMONT ADULT PROTECTIVE SERVICE. WITHIN THE 480 TIME FRAME. AS OF FEB 29, 2016, THE APS PHONE NUMBERS HAVE BEEN PLACED IN THE POLICY + PROCEDURE BOOK, THE MAR, AND THE DIRECTOR'S OFFICE.		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

DC5111

If continuation sheet 1 of 2

R206 POC accepted 3/3/16 JHamer RN/pme

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0119	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER CANTERBURY INN			STREET ADDRESS, CITY, STATE, ZIP CODE 46 CHERRY STREET SAINT JOHNSBURY, VT 05819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	